

Effective Date: April 13, 2011
Revised Date: October 12, 2011

CRITERIA FOR PRIOR AUTHORIZATION

Dextromethorphan/Quinidine (Nuedexta®)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
Dextromethorphan/Quinidine (Nuedexta®)

CRITERIA: (must meet all of the following)

- Patient must be 18 years of age or older.
- Patient must have a diagnosis of pseudobulbar affect (PBA).
- Patient does not have history of complete atrioventricular (AV) block without a pacemaker, congenital long QT syndrome, or heart failure.
- Patient is not currently receiving monoamine oxidase inhibitor therapy or discontinued their use in the last 14 days.
- Patient is not currently receiving any medications containing quinine, quinidine, or mefloquine.
- Patient is not currently receiving pimozide or thioridazine.

Prior Authorization will be approved for 1 (one) year.